**Texas Department of Insurance**
*Division of Workers' Compensation*
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name**
ELITE HEALTHCARE FORTH WORTH

**Respondent Name**
AMERICAN CASUALTY CO

**MFDR Tracking Number**
M4-14-0878-01

**Carrier's Austin Representative**
BOX NUMBER: 47

**MFDR Date Received**
NOVEMBER 1, 2013

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Received denial stating information ndoes not support service. Dr. Lopez – treating physician for this patient did a dictation pointing out key components for visit. Still received denial stating same reason."

**Amount in Dispute:** $170.89

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Upon receipt of the documentation for the MDR Medical Fee Dispute, Carrier again sent the documentation for review by Coventry Bill Review. Coventry Bill Review Services maintains that no additional allowable is due. as the documentation submitted by theprovider does not support a elvel IV CPT 99214 visit as per the AMA CPT guidelines. Specifically, Conventry Services indicated that the documentation is better described as a code 99213. Therefore, for the reasons noted above, reimbursement is not recommended for the disputed date of service."

**Response Submitted by:** Law Offices of Brian J. Judis

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| May 20, 2013 | 99214 | $170.89 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. Former 28 Texas Administrative Code §133.307, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, sets out the procedures for resolving medical fee disputes filed prior to June 1, 2012
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for E/M services

The services in dispute were reduced/denied by the respondent with the following reason codes:

- 1 – (150) Payer deems the information submitted does not support this level of service.
- 2 – (W1) Workers Compesnation State Fee Schedule Adjustment.

**Issues**

1. Did the requestor meet the requirements of 28 Texas Administrative Code §134.203?
2. Is the requestor entitled to reimbursement?

**Findings**

1. 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, "for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; … and other payment policies in effect on the date a service is provided…" Review of the submitted documentation finds that the requestor performed an office visit for the evaluation and management of an established patient. The American Medical Association (AMA) CPT code description for 99214 is:

   > Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.

   The 1997 Documentation Guidelines for Evaluation & Management Services is the applicable Medicare policy. It describes the documentation requirements for the service in dispute. Review of the documentation finds the following:

   - Documentation of the Detailed History
     - History of Present Illness (HPI) consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions. Documentation found listed two chronic conditions, this component was not met.
     - Review of Systems (ROS) requires two to nine systems to be documented. Documentation found listed one system, this component was not met.
     - Past Family, and/or Social History (PFSH) requires at least one specific item from any three history areas to be documented. No PFSH was found in the documentation; therefore, this component was not met.
   - Documentation of a Detailed Examination:
     - Requires at least six organ systems to be documented, with at least two elements per listed system. The documentation found listed 1 body/organ system: neurological. This component was not met.

   The division concludes that the documentation does not sufficiently support the level of service billed.

2. For the reasons stated above, the service in dispute is not eligible for payment pursuant to 28 Texas Administrtive Code §134.203(b),

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that reimbursement is not due. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| | | |
|---|---|---|
| | | October 10, 2014 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.